THE U.S. DEPARTMENT OF DEFENSE PHARMACOECONOMIC CENTER

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## DoD P&T Meeting Highlights . . . 2 - 8

Topics discussed at the 6 June 2001 DoD Pharmacy & Therapeutics (P&T) Executive Council meeting included:

- **Proton pump inhibitors (PPIs)**– Janssen recently reduced the FSS price for rabeprazole (Aciphex) to $0.22 per dose. The VA negotiated an early termination of its lansoprazole contract and replaced it with a BPA that prices lansoprazole at $0.55 per dose for VA facilities. The VA National Formulary now lists lansoprazole and rabeprazole in an open PPI class. The Defense Supply Center Philadelphia (DSCP) is exploring options with regard to DoD's omeprazole contract, which expires 30 Sep 01. The DoD national contract price for omeprazole is $1.09 per dose.
- **COX-2 inhibitors** - the Council agreed that management of this class should focus on two issues: accurate and efficient targeting of therapy to patients at greatest risk for GI adverse events, and reducing the unit cost of therapy.
- **Low molecular weight heparins/heparinoids (LMWHs)** - the Council concluded that enoxaparin and dalteparin are not sufficiently interchangeable for a closed class contract for the outpatient treatment and prophylaxis of DVT.
- **Topical corticosteroids** - fluocinonide 0.05% cream was added to the Basic Core Formulary

Issues discussed at the 7 June 2001 DoD P&T Committee meeting included calls to physicians regarding drugs in the NMOP Preferred Drug Program; cost avoidance from prior authorizations in the NMOP; availability of LMWHs from the NMOP (enoxaparin, dalteparin, and tinzaparin were added to the NMOP Formulary); a planned review of the NMOP Covered Injectables List; and controlled distribution of dofetilide (Tikosyn) and etanercept (Enbrel).

## Non-Sedating Antihistamine Contract: Questions and Answers . . . 9 - 10

The joint DoD/VA national pharmaceutical contract for non-sedating antihistamines (NSAs), awarded to Aventis Pharmaceuticals for fexofenadine (Allegra) 60- and 180-mg with an effective date of 1 May 2001, is the first joint closed class contract for DoD and the VA. In DoD facilities, the NSA contract requires that all **new** patients who have a clinical need for a NSA be prescribed either Allegra® 60 mg tablets or Allegra®180 mg tablets (unless a non-contracted NSA is medically necessary). The contract does not mandate switching current NSA patients to fexofenadine, but MTFs may decide to encourage their providers to switch patients. This article answers some common questions about the contract.

## PDTS Corner: Update on the Pharmacy Data Transaction Service . . . 11 - 13

As of 25 June 2001, DoD successfully accomplished worldwide deployment of the Pharmacy Data Transaction Service (PDTS). This article by COL (Ret.) Roger Williams, PDTS Clinical Support Coordinator, includes:

- **Drug-Drug Interaction Screening by PDTS**
- **DEA Web Page Access**
- **Unique Utilizers by Point of Service (<65/65+ years of age) for May and June 2001**

## Combination Therapy for Onychomycosis? . . . 14 - 15

Some providers add ciclopirox topical solution to systemic antifungal therapy for treating onychomycosis. There is no evidence that this combination works better, and it costs a lot more.

## In the News . . . 15 - 16

- **Revised labeling for cerivastatin (Baycol®; Bayer)**
- **Revised labeling for itraconazole (Sporanox®; Janssen) and terbinafine (Lamisil®; Novartis)**
- **Does it say "Lamisil" or "Lamictal"? Commonly confused drug names**
- **Updated CDC guidelines: Occupational exposure to hepatitis and HIV**

**Coming next issue: an updated look at statin therapy in DoD**

# DoD Pharmacy & Therapeutics (P&T) Committee Meeting Highlights

News from the 6-7 June meetings of the DoD P&T Executive Council and the DoD P&T Committee

**DoD P&T Executive Council Meeting (6 June 2001)**

- Levofloxacin/gatifloxacin
- Micronized glyburide
- Medications for overactive bladder
- Topical corticosteroids
- Sedative/hypnotics
- COX-2 inhibitors
- BCF Changes and Clarifications
- Issues to be Reviewed at the August DoD P&T Executive Council Meeting
- National Pharmaceutical Contracts
  - o Contract awards and renewals
  - o Financial impact of contracts
  - o Returned goods contract
  - o Proton pump inhibitor contract
  - o Potential contract for low molecular weight heparins/heparinoids
- Blanket Purchase Agreements
  - o Role of the DoD P&T Executive Council in the development of Blanket Purchase Agreements (BPAs)
  - o Status of BPAs for leutinizing hormone releasing hormone (LHRH) agonists
  - o Proposed BPA for metformin/glyburide (Glucovance; BMS) and glyburide extended release (Glucophage XR; BMS)

**DoD P&T Committee Meeting (7 June 2001)**

- National Mail Order Pharmacy (NMOP) Preferred Drug Program
- Prior Authorizations in the NMOP and Retail network
- Addition of Low Molecular Weight Heparins to the NMOP Formulary
- New Drugs Added to the NMOP Formulary

**Combined List: Changes to the Basic Core Formulary and National Mail Order Pharmacy (NMOP) Formulary**

Complete minutes of the meetings are available on the PEC website at **www.pec.ha.osd.mil/PT_Committee.htm**. The next meetings of the DoD P&T Executive Council and the DoD P&T Committee are scheduled for 15-16 August 2001.

## DoD P&T Executive Council Meeting (6 June 2001)

### Levofloxacin/Gatifloxacin

The Council considered a MTF request to delete levofloxacin from the BCF and add gatifloxacin. [Gatifloxacin is available to MTFs through an incentive price agreement at a price of $1.90 for the 200- and 400-mg tablets. The incentive price is contingent on gatifloxacin having a preferred or co-preferred formulary position at an individual MTF, but there are no market share requirements.] The Council voted to keep levofloxacin on the BCF, since removal would nullify the levofloxacin BPA. They reminded MTFs that the fluoroquinolone class is open on the BCF, so MTFs may add gatifloxacin to their formularies if they wish to take advantage of the lower price.

### Micronized Glyburide

The Council considered a MTF request to delete micronized glyburide from the BCF on the basis of limited use, uncertain clinical advantage, and greater cost than glyburide. The Council decided not to remove micronized glyburide from the BCF pending results of a joint DoD/VA contracting initiative for micronized glyburide, which is currently in progress.

### Medications for Overactive Bladder (OAB)

A number of MTF requests were submitted for addition of tolterodine extended release (Detrol LA) to the BCF. The requests coincided with a scheduled review of medications for OAB. The Council concluded that Ditropan XL, Detrol, and Detrol LA should not be added to the BCF because they do not offer sufficient clinical benefit to justify their significantly higher cost compared to oxybutynin immediate release.

### Requests for BCF Changes

Requests for additions and/or deletions to the BCF can be initiated by any DoD healthcare provider (including MTF pharmacists) using the Request Form available on the Basic Core Formulary page of the PEC website **(www.pec.ha.osd.mil)**. The form should be faxed or e-mailed to the DoD Pharmacoeconomic Center for consideration by the DoD P&T Committee. [**Editor's Note**: Requests received so far for the August 2001 meeting include deletion of quinidine from the BCF and addition of amiodarone.]

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Minutes for the meetings are available on the PEC website at:
**www.pec.ha.osd.mil/PT_Committee.htm**

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## Review of Topical Corticosteroids for the BCF

After reviewing the topical corticosteroids [grouped by potency category, ranging from Class I (Very High Potency Agents) to Class IV (Low Potency Agents)], the Council decided the following:

| Category | Current BCF agents | Added to the BCF | Comments |
|---|---|---|---|
| *Class I Agents (Very High Potency)* | None | None | Not generally considered to be primary care drugs |
| *Class II Agents (High Potency)* | None | Fluocinonide 0.05% cream | Fluocinonide represents 58% of all MTF purchases of Class II agents (by number of tubes) and is available under a VA/DoD national contract at approximately $0.10 per gram. (Costs per gram in this category range as high as $1.17 per gram). The 0.05% cream formulation represents the great majority of all purchases of fluocinonide products. MTFs may decide whether or not to add fluocinonide 0.05% ointment or solution to their formularies. |
| *Class III Agents (Medium Potency)* | "triamcinolone acetonide 0.1% topical." | None added. | Listing for triamcinolone was clarified to specify "triamcinolone acetonide 0.1% cream." |
| *Class IV Agents (Low Potency)* | None for general use; the BCF does list hydrocortisone 2.5% rectal cream | None | The Council discussed addition of hydrocortisone or desonide cream as a nonfluorinated Class IV topical corticosteroid agent for general use. The majority of MTFs already have hydrocortisone cream on their individual formularies and many also have desonide.<br>The Council did not add hydrocortisone cream or ointment to the BCF because the BCF generally does not include OTC medications [Editor's note: the only exceptions are insulin, test strips, insulin syringes and ferrous sulfate.] The Council also did not want to add desonide to the BCF because it costs approximately eight times more per gram than hydrocortisone, and the Council did not wish to mandate that facilities using hydrocortisone cream must also add desonide to their formularies. |
| According to input from dermatologists, primary care providers, and others, there is little or no difference within potency categories except for the difference between fluorinated and nonfluorinated agents [nonfluorinated agents cause less skin atrophy than fluorinated agents, particularly important for pediatric patients and for administration to the face] and availability in the desired vehicle (e.g., ointment, cream). | | | |

There are multiple systems for classification of topical corticosteroid agents, which may vary in potency based on drug, concentration, or formulation. The classification system used by the PEC in reviewing these medications is available as Appendix D of the DoD P&T Executive Council minutes.

## Review of Sedative/Hypnotic Medications for the BCF

After considering the relative safety, tolerability, efficacy, price and other factors for temazepam and zolpidem, the two sedative/hypnotics most commonly used in DoD, the Council decided not to add either drug to the BCF at this time. (See DoD P&T Executive Council minutes for further discussion.) There are currently no sedative/hypnotic agents on the BCF.

## Review of COX-2 Inhibitors

The Council agreed that management of the COX-2 inhibitors should focus on two issues:

- Accurate and efficient targeting of COX-2 inhibitor therapy to those patients at greatest risk for GI adverse events
- Reducing the unit cost of COX-2 inhibitors

According to the minutes,

> *"DoD faces difficulty in trying to address these two issues simultaneously. A closed class contract that offers BCF status for a COX-2 inhibitor could possibly achieve a significant price reduction, but many MTFs do not want COX-2 inhibitors to be added to the BCF. These MTFs do not have a COX-2 inhibitor on their formularies because they do not have sufficient funding and/or they want to target therapy by using the non-formulary special order process to provide COX-2 inhibitors only to patients who are at greatest risk for GI adverse events."*

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The Council agreed that the PEC should continue data analysis and provide feedback to MTFs to assist them in targeting therapy, while MTFs should analyze utilization and cost of COX-2s at the local level. The PEC will obtain feedback from MTFs concerning methods used to target COX-2 therapy and the accuracy and efficiency of those methods. The Council also concluded that a contract for COX-2 inhibitors should be pursued only if there is a mechanism to target therapy to patients who are at greatest risk for GI adverse events.

Please see DoD P&T Executive Council minutes for more detailed information concerning costs and usage of COX-2 inhibitors in MTFs, the NMOP, and retail network pharmacies.

## BCF Changes and Clarifications

- The BCF listing for digoxin oral was changed to eliminate the specification for "Lanoxin brand (Glaxo Wellcome) only," since an "A-rated" generic equivalent (Digitek; Bertek) is now available.
- The Council excluded Periostat from the BCF listing for doxycycline oral.
- The Council excluded Metadate CD from the BCF listing for methylphenidate oral. Please see DoD P&T Executive Council minutes for further discussion.

## Issues to be Reviewed at the August Meeting

The PEC is reviewing **topical medications for acne** and **anxiolytics**. Information on these drugs will be presented at the next meeting of the P&T Executive Council.

## National Pharmaceutical Contracts

### Contract awards and renewals

- The first joint DoD/VA closed class contract was awarded to Aventis Pharmaceuticals for the non-sedating antihistamine fexofenadine (Allegra) 60- and 180-mg tablets. Please see the article on Page 9 for more information. Previously released implementation guidance for the contract is available as Appendix B of the DoD P&T Executive Council minutes.
- DoD/VA single source contracts were awarded for the following drugs:
  - Ethinyl estradiol 35-mcg/norethindrone 1-mg tablets (Norinyl 1/35), 21s and 28s, to Watson Pharma
  - Norethindrone 35-mcg tablets (Nor-Q-D), 28s, to Watson Pharma
  - Ethinyl estradiol 35-mcg/1-mg ethynodiol diacetate (Demulen 1/35), 28s, to Pharmacia Corp.
  - Etodolac 200-, 300-mg capsules and 400-mg tablets, to Taro Pharmaceuticals
  - Hydrochlorothiazide 25-mg/50-mg tablets, to IVAX Pharmaceuticals (formerly Zenith-Goldline)
  - Prednisone 2.5-, 5-, 10-, 20-, and 50-mg tablets, to Pharmacia Corp.
  - Isosorbide mononitrate SA 30-, 60-, and 120-mg tablets, to Schwarz Pharma
  - Valproic Acid 250-mg capsules, to Sidmak Labs
  - Capsaicin 0.025% and 0.075% cream, to Qualitest Pharmaceuticals
  - Ticlopidine 250-mg tablets, to Par Pharmaceuticals
- As of 1 Jun 01, 44 joint VA/DoD national contracts have been awarded. Information on national pharmaceutical contracts, including NDC numbers and prices, is available on the DSCP website (**www.dmmonline.com)** or linked off the PEC website at **www.pec.ha.osd.mil/national_contracts.htm**

**Financial impact of contracts -** The estimated MTF cost avoidance due to national pharmaceutical contracts was $43.3 million for the first six months of FY 01. The $43.3 million in cost avoidance equals 7.9% of the $547.2 million that MTFs spent on pharmaceuticals through prime vendors during the first six months of FY 01. This figure does not include cost avoidance attributable to the non-sedating antihistamine contract. A summary of cost avoidance from national pharmaceutical contracts for FY 01 is provided in Appendix C of the DoD P&T Executive Council minutes.

[**Editor's note:** For comparison, the final estimate of MTF cost avoidance due to national pharmaceutical contracts was **$65.2 million in FY 00, which equals 6.3% of the $1.03 billion that MTFs spent on pharmaceuticals.** See Appendix A of the Feb 01 meeting of the DoD P&T Executive Council for FY 00 details.]

**Returned goods contract** – MAJ Cheryl Filby (DSCP) reported that, as of 5 June 01, 89 DoD facilities have signed up for the joint VA/DoD returned goods contract, which was awarded to Guaranteed Returns in Jan 01. More information on the Pharmaceutical Returns Management Program is available on the DSCP website **(www.dmmonline.com)**

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**Proton pump inhibitor contract -** Significant price reductions recently occurred in the proton pump inhibitor (PPI) market. Janssen lowered the FSS price of rabeprazole (Aciphex) to $0.22 per dose. In response to the market changes, the VA and TAP Pharmaceuticals have mutually agreed to cancel the VA's national contract for lansoprazole (Prevacid) in favor of a BPA that sets the price for both strengths of lansoprazole at $0.55. Lansoprazole will remain on the VA National formulary, but the PPI class is now "open," so VA facilities may use other PPIs. The DoD national contract price for omeprazole (Prilosec) is $1.09 per dose. The current option year expires on 30 Sep 01. The DoD P&T Executive Council strongly urges DSCP to negotiate a termination of the DoD national contract for omeprazole in a manner similar to what the VA negotiated.

**Potential contract for low molecular weight heparins/heparinoids (LMWHs) -** The Council assessed the therapeutic interchangeability of enoxaparin (Lovenox) and dalteparin (Fragmin) for outpatient treatment of DVT and prophylaxis of DVT and/or pulmonary embolism (PE) following hip or knee replacement surgery. The Council considered the relative safety, tolerability, and efficacy of the two drugs for the given indications, as well as FDA approval status for specific indications, packaging and ease of use, literature reports of health systems with existing interchange programs, current market share at MTFs, and input from a cross section of MTF providers (Internal Medicine, Cardiology, Hematology/Oncology, Ob/Gyn, Emergency Medicine, Orthopedics, and Family Practice). The Council concluded that:

> *"Enoxaparin and dalteparin are not sufficiently interchangeable for a closed class contract for the outpatient treatment and prophylaxis of DVT."*

A more extensive discussion of the factors considered and a summary of survey results is given in the DoD P&T Executive Council minutes.

## Blanket Purchase Agreements

**Role of the DoD P&T Executive Council in the development of Blanket Purchase Agreements (BPAs) -** The DoD P&T Executive Council and Defense Supply Center Philadelphia (DSCP) agreed that DSCP will coordinate all proposed DoD and DoD/VA BPAs with the Council (or the PEC acting on its behalf) to ascertain whether the terms and conditions are in accord with the Council's strategy for managing the pertinent drug class. The DoD P&T Executive Council will accept or reject the terms of the agreement. If the P&T Executive Council accepts the agreement, DSCP will then be responsible for the content of the agreement in regard to legal and contractual sufficiency. Individual MTFs and TRICARE regions may continue to negotiate facility-specific incentive agreements. However, MTFs and TRICARE regions are encouraged to forward any agreements to DSCP for a review of legal sufficiency.

**Status of BPAs for leutinizing hormone releasing hormone (LHRH) agonists -** A BPA makes goserelin (Zoladex) available to MTFs at the VA national contract price in exchange for attainment of an 80% overall share of the MTF prescriptions for LHRH agonists for prostate cancer by 1 Sep 2001. A BPA from TAP Pharmaceuticals makes leuprolide (Lupron) 1, 3, and 4-month depots available at a cost per dose just slightly higher than Zoladex. TAP modified the BPA in May 2001 so that the BPA price is available without any market share requirements (the original BPA required that Lupron attain an 80% market share within 6 months).

Because market share trends suggest that the 80% market share goal for Zoladex will probably not be achieved, the Council asked DSCP and the PEC to talk with Astra Zeneca about the potential extension of the BPA price beyond August 2001 even if the 80% market share goal is not achieved. The Council also asked the PEC to assess the potential for a contracting action for LHRH agonists for prostate cancer and present a recommendation at the August 2001 P&T Executive Council meeting. This could potentially be a joint VA/DoD contract, since the VA contract for Zoladex expires in February 2002.

**Proposed BPA for metformin/glyburide (Glucovance; BMS) and glyburide extended release (Glucophage XR; BMS) -** In reference to a proposed BPA for these agents, the Council concluded that "there is insufficient evidence to prove conclusively that the extended release and combination dosage forms offer a clinically significant advantage regarding safety, tolerability, or efficacy over immediate release metformin or immediate release metformin plus generically available glyburide." They noted that while the proposed BPA would provide an economic benefit to DoD in the short run, it might be costly in the long run. The Council also noted that this does not preclude an MTF from adding Glucovance or Glucophage XR to its formulary, but advised MTFs to consider the local usage patterns and the degree to which their patients are getting prescriptions for Glucovance or Glucophage XR filled in retail pharmacies where the cost to DoD is much higher. (See DoD P&T Executive Council minutes for further discussion.)

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# DoD P&T Committee Meeting (7 June 2001)

## Non-Preferred/Preferred Drug Pairs In The NMOP

On 1 April 2001, the NMOP contractor, Merck-Medco, ceased making calls to physicians concerning all non-preferred/preferred drug pairs in the NMOP Preferred Drug Program except diltiazem. The change was made in order to accommodate the increased NMOP workload from the expansion of the pharmacy benefit to all beneficiaries over 65 years of age. Phone calls for diltiazem will continue because of the national contract for diltiazem extended release (Tiazac) and the high cost avoidance per attempted provider contact associated with this non-preferred/preferred drug pair. The program realized a $2.8 million cumulative cost avoidance over its 22-month duration. (See Appendix B in the DoD P&T Committee minutes for details.)

## Prior Authorizations (PAs)

**Cost avoidance from NMOP prior authorizations (PAs) -** The committee discussed cost avoidance calculations for drug in the NMOP prior authorization program. No changes were made to the program. See DoD P&T Committee minutes for more details.

**Temporary lapse in the NMOP PA program -** The NMOP PA program was suspended from mid April 01 to early May 01 to accommodate large increases in NMOP workload due to the expansion of the pharmacy benefit to all beneficiaries over 65 years of age.

**Utilization of the NMOP and retail network pharmacies for drugs subject to PA -** The committee reviewed longitudinal data concerning utilization and costs of COX-2 inhibitors, brand name nonsteroidal anti-inflammatory drugs (NSAIDs) and generic NSAIDs in Regions 3 and 4 before and after removal of the PA for COX-2 inhibitors in the retail network. [The COX-2 inhibitor PA was withdrawn in the retail network in Aug 00 because federal regulations governing TRICARE currently allow prior authorizations to be applied in the retail pharmacy networks only for clinical considerations (appropriateness of therapy), and not for cost-effectiveness considerations.] The committee requested that the PEC utilize data from the Pharmacy Data Transaction Service (PDTS) to analyze the extent to which patients who are denied prescriptions for COX-2 inhibitors in the NMOP subsequently fill these prescriptions at retail network pharmacies.

**Antifungals for onychomycosis -** Ciclopirox topical solution (Penlac Nail Lacquer) was added to the existing NMOP PA for antifungals for onychomycosis as of 10 May 01. No problems with NMOP implementation were reported. One of the MSCS pharmacy directors expressed concern about combination therapy with oral antifungals and ciclopirox being prescribed by a small number of providers. (See article on Page 14)

## Low Molecular Weight Heparins (LMWHs) to be available from the NMOP

While the volume of prescriptions is expected to be low, the committee agreed that there is no reason to not have low molecular heparins designed for self-administration available through the NMOP for those patients who might benefit. The committee added LMWHs (dalteparin, enoxaparin, and tinzaparin) to the NMOP formulary. The low molecular weight heparinoid, danaparoid, was not added because it is indicated for intravenous administration only and is unlikely to be administered as an outpatient medication.

## Review of NMOP Covered Injectables List

An MCSC pharmacy director requested removal of Zoladex from the NMOP Covered Injectables list, since it is an implant that requires an office visit and insertion under sterile conditions. The Committee requested that the PEC review the NMOP Covered Injectables list to identify items not designed for self-administration or commonly used in an outpatient setting and review the current utilization of these medications through the NMOP. The committee clarified that the potential for self-administration is only one of the factors for considering drugs for the NMOP Covered Injectables List. Other factors include the feasibility of dispensing the medications through mail order (Merck-Medco's mail order facilities are not set up to handle sterile compounding of parenteral products) and the relative likelihood that the medications will be needed on an outpatient basis. No changes to the Covered Injectables list were made, pending results of the review.

## Controlled Distribution of Dofetilide (Tikosyn) and Etanercept (Enbrel)

**Dofetilide (Tikosyn) -** Because of specialized educational requirements mandated by the FDA, dofetilide is only available for outpatient use through Stadtlander's Pharmacy/CVS Procare (which is a non-network pharmacy for DoD beneficiaries). COL Davies reported on effects to develop a new payment

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mechanism to handle not just dofetilide, but also the increasing number of drugs with unique distribution systems.

**Etanercept (Enbrel)** – Since MTF pharmacies, unlike retail pharmacies, are not required to submit patient enrollment numbers to obtain etanercept, DoD beneficiaries can obtain etanercept from MTF pharmacies even if they did not enroll with Immunex. However, unenrolled patients may experience problems if they need to obtain etanercept from a source other than an MTF pharmacy.

A process has been established for patients not enrolled with the manufacturer who have been receiving etanercept from a MTF and who wish to obtain their medication through the retail network, or who have separated from the military, to obtain enrollment numbers and receive etanercept through the NMOP or a retail network pharmacy. Patients who have not previously received etanercept (new starts) are subject to the same waiting list procedures as civilian patients. A letter outlining this process (already sent to the field by the pharmacy consultants/specialty leaders) is available as Appendix D of the DoD P&T Committee minutes.

## Newly Approved Drugs Added to the NMOP Formulary

The Committee determined the NMOP formulary status; NMOP or retail network formulary restrictions (quantity limits or prior authorization); and the Basic Core Formulary (BCF) status for 11 new drugs. Please see Appendix A in the DoD P&T Committee minutes for additional comments. None of these drugs were added to the BCF. Fluoxetine 90-mg capsules (Prozac Weekly) were specifically excluded from the existing BCF listing for fluoxetine.

New drugs added to the NMOP Formulary at this meeting were:

- **Ziprasidone capsules** (Geodon; Pfizer)
- **Galantamine tablets** (Reminyl; Johnson & Johnson)
- **Bimatoprost ophthalmic solution, 0.03%** (Lumigan; Allergan)
- **Travoprost ophthalmic solution, 0.004%** (Travatan; Alcon)
- **Insulin glargine [rDNA origin] injection** (Lantus; Aventis)
- **PEG-interferon alfa-2b powder for SC injection** (PEG-Intron; Schering) (additional comments in DoD P&T Committee minutes)
- **Fluticasone / salmeterol powder for inhalation 100/50, 250/50, and 500/50 mcg per inhalation** (Advair Diskus; Glaxo SmithKline) *Quantity Limits:* 1 inhaler (60 blisters) per 30 days (retail), 3 inhalers (180 blisters) per 90 days (NMOP). (Additional comments in DoD P&T Committee minutes)
- **Formoterol fumarate powder for inhalation** (Foradil; Novartis) *Quantity Limits:* 1 inhaler (60 capsules) per 30 days (retail), 3 inhalers (180 capsules) per 90 days (NMOP)(Additional comments in DoD P&T Committee minutes)
- **Fluoxetine HCl 90-mg capsules** (Prozac Weekly; Lilly) *Quantity Limits:* 4 capsules (one blister pack) per 30 days (retail); 12 capsules (3 blister packs) per 90 days (NMOP). Excluded from the BCF listing for fluoxetine. (Additional comments in DoD P&T Committee minutes)
- **Esomeprazole capsules** (Nexium; AstraZeneca) Designated as a non-contract drug on the NMOP Formulary. Prescriptions for esomeprazole may be filled through the NMOP only if documented medical necessity is established. (Additional comments in DoD P&T Committee minutes.)

**Imatinib mesylate** (Gleevec; Novartis) *Quantity Limits:* Limited to 45 days supply in the NMOP; general rule applies in the retail network. (Additional comments in DoD P&T Committee minutes.)

# Summary of Changes to the Basic Core Formulary and National Mail Order Pharmacy Formulary

Resulting from the June 2001 meetings of the DoD Pharmacy and Therapeutics Executive Council and the DoD Pharmacy and Therapeutics Committee

## 1. BCF Changes (For more information see minutes of the June 6 DoD P&T Executive Council meeting)

### A. Additions to the BCF

1) Fluocinonide 0.05% cream

### B. Changes and clarifications to the BCF

1) The BCF listing for digoxin oral was changed to remove the specific brand designation for brand name Lanoxin.
2) The BCF listing for doxycycline oral was clarified to exclude doxycycline 20-mg capsules (Periostat).
3) The BCF listing for methylphenidate oral was clarified to exclude Metadate CD.
4) The BCF listing for triamcinolone acetonide 0.1% topical was clarified to specify triamcinolone acetonide 0.1% cream.
5) The BCF listing for fluoxetine was clarified to exclude Prozac Weekly. (see Appendix A in minutes of the June 2001 P&T Committee meeting)

## 2. NMOP Formulary Changes (For more information see minutes of the 7 Jun 2001 DoD P&T Committee Meeting)

### A. Additions to the NMOP Formulary

1) Low Molecular Weight Heparins (dalteparin, enoxaparin, tinzaparin)
2) Ziprasidone (Geodon; Pfizer)
3) Galantamine (Reminyl; Johnson & Johnson)
4) Bimatoprost ophthalmic solution, 0.03% (Lumigan; Allergan)
5) Travoprost ophthalmic solution, 0.004% (Travatan; Alcon)
6) Insulin glargine [rDNA origin] injection (Lantus; Aventis)
7) PEG-interferon alfa-2b powder for SC injection (PEG-Intron; Schering)
8) Fluticasone/salmeterol powder for inhalation (Advair Diskus; Glaxo SmithKline)
9) Formoterol fumarate powder for inhalation (Foradil; Novartis)
10) Fluoxetine hydrochloride 90-mg capsule (Prozac Weekly; Lilly)
11) Imatinib mesylate (STI-571) (Gleevec; Novartis)

### B. Changes to the NMOP Formulary

1) Esomeprazole (Nexium; Astra Zeneca) identified as a non-contract drug on the NMOP Formulary. Prescriptions for esomeprazole may be filled through the NMOP only if documented medical necessity is established.

### C. Changes to the NMOP Preferred Drug Program

1) Calls to physicians concerning all non-preferred/preferred drug pairs in the NMOP Preferred Drug Program, except diltiazem, were discontinued 31 Mar 01. Calls requesting switches for non-contracted brands of diltiazem extended release (e.g., Cardizem CD, Dilacor XR, Diltia XT, Cartia XT, and generics) to the contract agent (Tiazac) will continue.

## 3. Quantity Limit Changes (NMOP and retail network)

A. Fluticasone/salmeterol powder for inhalation (Advair Diskus; Glaxo SmithKline) - 1 inhaler (60 blisters) per 30 days (retail), 3 inhalers (180 blisters) per 90 days (NMOP)
B. Formoterol fumarate powder for inhalation (Foradil; Novartis) - 1 inhaler (60 capsules) per 30 days (retail), 3 inhalers (180 capsules) per 90 days (NMOP)
C. Fluoxetine hydrochloride 90-mg capsule (Prozac Weekly; Lilly) - 4 capsules (one blister pack) per 30 days (retail); 12 capsules (3 blister packs) per 90 days (NMOP)
D. Imatinib mesylate (STI-571) (Gleevec; Novartis) - Limited to 45 days supply in the NMOP; general rule applies in the retail network

## 4. Changes to the Prior Authorization Program (NMOP and Retail Network) - None

# The Non-Sedating Antihistamine Contract
## Questions and Answers

The joint DoD/VA national pharmaceutical contract for non-sedating antihistamines (NSAs) was awarded to Aventis Pharmaceuticals for fexofenadine (Allegra®). The NSA contract is the first joint closed class contract for DoD and the VA. It applies to all DoD and VA medical treatment facilities (MTFs).

The NSA contract base period is 1 May 2001 through 30 April 2002. There are 4 one-year renewal options. Contract prices are listed in the table below.

**DoD/VA Contract Prices for Fexofenadine (Allegra)**

| Strength | Dosage Form | NDC | Price per tablet/capsule | QTY per Package |
|---|---|---|---|---|
| 60 mg | Tablet | 00088-1107-47 | $0.37 | 100 |
| 60 mg | Capsule* | 00088-1102-55 | $0.37 | 500 |
| 180 mg | Tablet | 00088-1109-47 | $0.60 | 100 |

* Production of the Allegra 60-mg capsule will be phased out over the next 12 months in favor of the tablet formulation. The PEC recommends that MTFs not add the 60-mg capsule to their formularies, since this would necessitate switching patients to the tablet formulation in the near future. The contract price of $0.37 for the 60 mg capsule only applies to the 500-count package size and will apply only until the 500-count package size of the 60 mg tablet is available.

***Q: Is guidance available for implementation of the contract?***

**A:** The implementation guidance for the NSA contract (previously sent to MTFs) is available as Appendix B of the 6 June 01 DoD P&T Executive Council minutes.

***Q: How does this closed class NSA contract affect my MTF formulary?***

**A:** Fexofenadine (Allegra) 60- and 180-mg tablets are added to the Basic Core Formulary (BCF) and **must** be on all MTF formularies. Claritin® 10mg tablets and 10mg Reditabs® are **not** allowed on any MTF formulary. Any new NSAs approved by the FDA are not allowed on any MTF formulary while this contract is in effect.

***Q: Do I have to remove cetirizine [Zyrtec®] from my formulary?***

**A:** No. Cetirizine (Zyrtec®) is classified as a second-generation antihistamine but **not** a NSA. Hence, this contract does not affect the current or future BCF or MTF formulary status of Zyrtec® products.

***Q: How does the contract affect prescriptions for NSAs?***

**A:** The contract requires that all **new** patients who have a clinical need for a NSA be prescribed either Allegra® 60 mg tablets or Allegra®180 mg tablets. If a new NSA patient fails to achieve adequate symptom relief or experiences unacceptable side effects, etc. with Allegra® and requires a NSA, the non-contracted NSA may be prescribed and dispensed under medical necessity provisions. The contract does not require switching patients who are already taking another NSA to the contracted agent, but **MTFs may decide to encourage their providers to switch patients.**

***Q: Why would MTFs decide to switch patients to Allegra if the contract does not require them to do so?***

**A:** Allegra ($0.60 per daily dose) costs much less than Claritin ($1.23 per daily dose) and Zyrtec ($0.93 per daily dose). MTFs could save more than $10 million dollars annually by converting 50% of current Zyrtec and Claritin usage to Allegra.

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### *Q: What about other loratadine and fexofenadine dosage forms such as the decongestant combination products, pediatric syrups, and the 30-mg fexofenadine tablet? What about pediatric patients?*

**A:** The decongestant combinations were not included in the NSA contract because the market shares of these agents are very small. They are more expensive than the contracted dosage forms. If a patient has a clinical need for a decongestant, the PEC recommends use of generic pseudoephedrine in addition to Allegra® 60- or 180-mg tablets. The PEC also discourages routine use of non-contracted combination products in lieu of the contracted agents, since this may result in unnecessary decongestant use and circumvents use of the contracted drugs.

The contract does not apply to pediatric dosage forms. MTFs are free to add pediatric dosage forms (30-mg Allegra® tablets and/or Claritin® syrup) to their formularies as needed for pediatric patients or patients who cannot swallow tablets.

### *Q: Is Allegra® waiverable in aircrew members?*

**A:** Yes. Both Allegra® and Claritin® are waiverable in aircrew members for all three services. [If treating seasonal or perennial allergic rhinitis, nasal steroids are also waiverable in aircrew members.]

### *Q: Does this contract apply to the National Mail Order Pharmacy (NMOP) and/or the Managed Care Support Contractors (MCSCs)?*

**A:** The contract price for Allegra applies to the NMOP, but the contract does not affect the current or future status of any Allegra®, Claritin®, or Zyrtec® product on the NMOP formulary. All Allegra®, Claritin® and Zyrtec® products remain available through the NMOP. This contract does not apply to the MCSC retail network pharmacies.

### *Q: How will NSA usage be monitored?*

**A:** The Pharmacy Data Transaction Service (PDTS) will provide data regarding the dispensing of NSA prescriptions across the entire DoD system including MTFs, the NMOP, and the MCSC retail network pharmacies.

### *Q: Who are the PEC points of contact for the NSA contract?*

**A:** LTC Edward Zastawny BSC, USAF, DoD Pharmacoeconomic Center, Fort Sam Houston, TX, (210) 295-9637, e-mail: **Edward.Zastawny@amedd.army.mil**

LCDR Ted Briski MSC, USN, DoD Pharmacoeconomic Center, Fort Sam Houston, TX, (210) 295-9047, e-mail: **Ted.Briski@amedd.army.mil**

Eugene Moore, Pharm.D, DoD Pharmacoeconomic Center, Ft Sam Houston, TX, (210) 295-9645, e-mail: **Eugene.Moore@amedd.army.mil**

# PDTS Corner: Update on the Pharmacy Data Transaction Service

**COL (Ret.) Roger Williams, PDTS Clinical Support Supervisor**

In June, DoD successfully accomplished worldwide deployment of the Pharmacy Data Transaction Service (PDTS). The last Military Treatment Facility (MTF) to activate PDTS, Seymour Johnson AFB, did so on 25 June 2001, while the last two Managed Care Support Contractor (MCSC) retail networks were activated in April 2001.

To put this accomplishment into perspective, PDTS is now processing more than 1.5 million pharmacy transactions weekly, with transactions generated from over 600 military dispensing pharmacies located in the United States and 17 foreign countries; five retail pharmacy networks consisting of approximately 40,000 retail pharmacies; and a mail order pharmacy with 12 different dispensing locations.

PDTS links three distinctly different points of service to one common database. It is a first not just for the Federal government, but for the entire managed care community. While many private sector Pharmacy Benefit Managers (PBMs) link the databases from their retail network pharmacies with a mail order pharmacy, no one has ever successfully tied together dispensing operations from so many disparate points of service, with pharmacies located worldwide. Implementation of PDTS is indeed a success story for DoD.

## Drug-Drug Interaction Screening by PDTS

A key patient safety feature of PDTS is the Prospective Drug Utilization Review (ProDUR) process, which (among other things) provides for drug-drug interaction screening on all medications filled by a DoD beneficiary at any MHS point of service (MTFs, the National Mail Order Pharmacy, or retail network pharmacies).

As more MTFs and MCSCs activated PDTS, the number of potential drug interactions detected increased. Both pharmacy personnel and providers need to be aware that since PDTS is now activated, they will receive information that was not previously available.

At the present time, the primary focus is on Level 1 drug-drug interactions (DDIs) —drug combinations where concurrent use is **contraindicated**. It is **important** to note that because of the way they are identified, the Level 1 DDIs detected represent only **potential** interactions—it is possible that the time periods of the two prescriptions do not in fact overlap or that patients have already been instructed to discontinue one of the interacting medications. However, it is also possible that questioning the patient about their use of other medications can prevent a potentially fatal adverse event.

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**Increase in the Number of Level-1 Drug-Drug Interactions Detected with Implementation of PDTS across the MHS**

| | | PDTS Deployment Status | | |
|---|---|---|---|---|
| **Month** | **Number of Level 1 Drug-Drug Interactions** | **CHCS Host Sites** | **MCSCs** | **NMOP** |
| Dec 00 | 112 | 10 | 2 | yes |
| Jan 01 | 242 | 26 | 2 | yes |
| Feb 01 | 257 | 46 | 3 | yes |
| Mar 01 | 487 | 63 | 3 | yes |
| Apr 01 | 937 | 84 | 5 | yes |
| May 01 | 1297 | 96 | 5 | yes |
| Jun 01 | 1793 | 104 | 5 | yes |

## Number of Potential Level 1 Drug-Drug Interactions by Point of Service

In February, the PDTS Customer Service Support Center began a program of reporting Level 1 Drug interactions identified in PDTS sorted by Point of Service. Below is a breakout of those transactions along with the number and percentage of transactions reversed by the dispensing site.

| | Number of Level 1 Drug-Drug Interactions Reversed / Total Number of Level 1 Drug-Drug Interactions (Percent Reversed) | | | |
|---|---|---|---|---|
| **Period** | **Total** | **MTFs** | **MCSCs** | **NMOP** |
| 1-20 Feb | 55/227 (24%) | 14/78 (18%) | 33/107 (31%) | 8/42 (19%) |
| 1-10 Mar | 9/135 (7%) | 0/75 (0%) | 6/44 (14%) | 3/16 (19%) |
| 11-31 Mar | 48/352 (14%) | 17/174 (10%) | 13/131 (10%) | 15/47 (32%) |
| 1-15 Apr | 68/391 (17%) | 13/130 (10%) | 35/162 (22%) | 20/99 (20%) |
| 16-30 Apr | 59/546 (11%) | 11/184 (6%) | 22/234 (9%) | 26/128 (20%) |
| 1-15 May | 64/611 (10%) | 19/232 (8%) | 22/280 (8%) | 23/99 (23%) |
| 16-31 May | 85/686 (12%) | 29/299 (10%) | 42/294 (14%) | 14/93 (15%) |
| 1-15 Jun | 102/830 (12%) | 38/364 (10%) | 39/351 (11%) | 25/115 (22%) |
| 16-30 Jun | 93/963 (10%) | 36/442 (8%) | 33/375 (9%) | 24/146 (16%) |

There are similarities in the specific potential Level 1 Drug-drug interactions reported. Frequently reported interactions include nitroglycerin products and sildenafil; carbidopa-levodopa and selegiline; cerivastatin sodium and gemfibrozil or fenofibrate; ketorolac tromethamine and other NSAIDs (ibuprofen and naproxen); and isotretinoin interactions with doxycycline, minocycline, or tetracycline.

**Combined Table: Top 10 Potential Level 1 Drug-Drug Interactions at MTFs, MCSC Retail Network Pharmacies, and the NMOP** (Based on Dispensed Date Period 1-30 June 2001)

| | Frequency of Occurrence | | |
|---|---|---|---|
| **Medications** | **MTF** | **MCSC** | **NMOP** |
| Amiodarone / Gatifloxacin | * | * | 4 |
| Amitriptyline HCl / Selegiline HCl | * | * | 5 |
| Carbidopa-levodopa / Selegiline HCl | 51 | 49 | 33 |
| Cerivastatin sodium / Fenofibrate, micronized | 33 | 41 | 14 |
| Cerivastatin sodium / Itraconazole | * | * | 5 |
| Cerivastatin sodium / Gemfibrozil | 16 | 20 | 11 |
| Cerivastatin sodium / Ketoconazole | * | * | 4 |
| Doxycycline hyclate / Isotretinoin | 15 | 15 | * |
| Dihydroergotamine mesylate / Sumatriptan succinate | 18 | * | * |
| Entacapone / Selegiline HCl | * | * | 6 |
| Hydrocodone bitartrate-APAP / Selegiline HCl | * | 14 | * |
| Ibuprofen / Ketorolac tromethamine | 94 | 32 | * |
| Isotretinoin / Minocycline HCl | 25 | 19 | * |
| Isotretinoin / Tetracycline HCl | * | * | 4 |
| Itraconazole / Simvastatin | * | 16 | * |
| Ketorolac tromethamine / Naproxen | 48 | 25 | * |
| Linezolid / Meperidine HCl | 18 | * | * |
| Nitroglycerin / Sildenafil citrate | 38 | 26 | 43 |
| * Not on top ten list for point of service | | | |

# PDTS Corner: Update on the Pharmacy Data Transaction Service

## DEA Web Page Access

Access to the DEA Web Page was only supposed to be for a limited time to assist sites with database cleanup prior to PDTS activation. Since all MTFs are up and running on PDTS, the contract for DEA Web page access was renewed for only a few number of licenses. However, there have been many requests from sites for continued access. The CSSC anticipates that access to the DEA Web Page will again be available to MTF sites by mid-August.

In the meantime, please contact the PDTS CSSC at 800-600-9332 (press #1 for PDTS, press #1 for Pharmacist) and a Customer Service Coordinator will assist you. If your site has numerous providers whose data needs to be cleaned up, you can e-mail a list of providers to the PDTS CSSC at **tmssc.dea#@brooks.af.mil.** A CSSC staff member will look up the DEA numbers and provide the list back to the site in a reasonable amount of time.

## Monitoring Drug Usage

### Q: How many unique utilizers are using MTFs, MCSC retail network pharmacies, or the NMOP?

**A.** As a sample of what PDTS enables the CSSC to analyze, here are some figures retrieved from PDTS for May and June 2001:

| Unique Utilizers | May 01 | | | June 01 | | |
|---|---|---|---|---|---|---|
| | < 65 | 65+ | Total | < 65 | 65+ | Total |
| **MTFs** | 829,791 | 294,697 | 1,124,488* | 1,086,130 | 362,236 | 1,448,366** |
| **MCSC pharmacies** | 369,519 | 186,780 | 556,299 | 362,933 | 196,662 | 559,595 |
| **NMOP** | 41,786 | 62,809 | 104,595 | 44,768 | 74,291 | 119,059 |

*MTFs still had 8 CHCS Host sites not active as of the end of May
**All MTFs sites were active as of 25 June 01

## Contacting the PDTS Customer Service Support Center

The Customer Service Support Center started 24/7 operation as of 2 April 01, with the beginning of overseas deployment. To contact the CSSC, call:

1-800-600-9332, DSN 240-4150, or
(210) 536-4150, and select Option 1.

OCONUS sites: The 800 number for OCONUS sites is your AT&T access code followed by 800-981-5339.

## For More Information about PDTS

Visit the Pharmacy Data Transaction Service Page on the TRICARE Pharmacy Site **(www.tricare.osd.mil/pharmacy/data_trans.htm)** or see back issues of the *PEC Update* **(www.pec.ha.osd.mil/ac03000.htm)**

- **Mar 2001:** "What is PDTS?"; documents on drug file validation and finding out why a prescription was not processed by PDTS; contacting the CSSC; and the differences between drug interaction definitions in CHCS and PDTS.
- **Jan 2001:** Latest news, "Lessons Learned" from MTF activations of PDTS
- **Dec 2000:** Accessing the TMSSC InfoNet site
- **Oct 2000:** More info on PDTS, PDTS trifold brochure for providers, change of access numbers and hours of operation for the CSSC, provider validation Ad Hoc report
- **Jan 2000:** The PDTS Customer Service Support Center

## A Note about Last Issue's Article about the Differences between Drug Interaction Definitions in CHCS and PDTS

While both definitions are based on and utilize First Data Bank as a reference source, PDTS uses the newer version of DDIM 3.2 and CHCS uses DDIM 3.0. (Today, the industry standards are 3.1 or 3.2. The 3.0 version is no longer supported for the commercial environment and 3.1 will soon be phased out.) As a result, the definitions of a Level 1, 2 and 3 drug interaction as reported by PDTS are different than CHCS.

# Combination Therapy for Onychomycosis?

Some providers have recently started using ciclopirox nail lacquer in addition to systemic oral antifungal therapy to treat onychomycosis. The presumed intent is to increase the cure rate of the oral antifungals, to decrease the time to cure, decrease the length of therapy, or decrease the rate of recurrence. Combination therapy for onychomycosis is not supported by clinical evidence.

The Penlac® package insert states that:

> "*No studies have been conducted to determine whether ciclopirox might reduce the effectiveness of systemic antifungal agents for onychomycosis. Therefore, the concomitant use of [Penlac®] and systemic antifungal agents for onychomycosis, is NOT recommended.*"

Dermatology experts consulted for this article do not use combination therapy to treat onychomycosis. Although these agents may have additive or even synergistic activity in onychomycosis, their actions may also be antagonistic to one another. Further studies need to be done to evaluate the possible benefit of this combination therapy and whether the incremental cost is worth the theoretical incremental benefits.

As pointed out in a previous article in the PEC Update on cost effective treatment of onychomycosis (**www.pec.ha.osd.mil/Updates/0002web/0002page.htm**), the first step is to make **a definitive diagnosis of a fungal infection** using KOH, PAS stain, or fungal culture. Due to risks for serious adverse effect with systemic antifungals, labeling for both terbinafine and itraconazole was recently changed to recommend that healthcare providers obtain nail specimens for laboratory confirmation of fungal infection prior to prescribing the medications for onychomycosis. (See article, Page 16) A study published in CUTIS (1999;64:407-10) showed that as many as 35% of patients empirically diagnosed with onychomycosis did not have a fungal infection.

Terbinafine is a cost-effective choice for toenail onychomycosis. The recommended course of therapy is 250mg po QD for 12 weeks (6 weeks for fingernails). Although not FDA approved, pulse therapy with terbinafine (250mg po BID for 1 week a month, using 2 pulses for fingers, 3 pulses for toes) has been evaluated. Based on evidence from two small studies, the efficacy rate of pulse-dosed terbinafine appears similar to that achieved with standard QD dosing.

See table on the following page for a comparison of costs for various onychomycosis treatment regimens.

**The bottom line:** Based on the information available today, the combination of systemic and topical therapy (specifically ciclopirox nail lacquer) for onychomycosis cannot be recommended.

## What is Penlac®?

Ciclopirox nail lacquer (Penlac®) is a recently approved topical antifungal medication for the treatment of onychomycosis. The topical solution is applied daily (8 hours before washing) to the entire nail plate, hyponychium, nail bed, under the surface of the nail (if possible), and 5 mm of the surrounding skin. Treatment should be continued for at least 48 weeks in conjunction with weekly nail trimming by the patient AND removal of the unattached, infected nail by a health care professional as frequently as every month. Even with this "labor intensive" regimen, ciclopirox was able to produce a clear or almost clear toenail in fewer than 12% of clinical trial patients.

Penlac® comes as an 8% solution in a 3.3 ml bottle. The DAPA price is $37.17 for a 3.3 ml bottle with an attached applicator brush in the cap. The actual cost of drug therapy is difficult to estimate. The amount of solution required depends on the number of nails treated, the duration of therapy, and the amount applied. A patient could easily require more than two bottles to complete a 48-week course of therapy. The cost of return visits to a health professional every month for removal of the infected nail must be included in the total cost of Penlac® therapy.

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## Treatment of Toenail Onychomycosis Cost Comparison (Sorted by cost / regimen)

| Drug | Dose (mg) | Regimen | Pulse/ Continuous | Cost/ unit (tab,cap, or bottle | Duration (days) | # doses | Cost*/ regimen |
|---|---|---|---|---|---|---|---|
| Terbinafine tablets [Lamisil®] | 250 | 250mg po BID | Pulse | $3.77 | 90 | 21 | $186.06 |
| Itraconazole capsules [Sporanox®] | 100 | 200mg po BID | Pulse | $3.49 | 90 | 21 | $357.84 |
| Terbinafine tablets [Lamisil®] | 250 | 250mg po QD | Continuous | $3.77 | 90 | 90 | $397.80 |
| Ciclopirox topical [Penlac® Nail Lacquer] | | Applied to affected nail(s) QD | Continuous | $37.17 | 336 (48 wks) | 336 | $496.51 |
| Itraconazole capsules [Sporanox ®] | 100 | 200mg po QD | Continuous | $3.49 | 90 | 90 | $766.80 |

*DoD costs as of March 2001

**Assumptions**

Toenail onychomycosis
12 weeks therapy for oral agents, 48 weeks for ciclopirox topical
Pulse dosing = 1 week/month, 2 pulses for fingernails, 3 pulses for toenails
For ciclopirox topical (Penlac® Nail Lacquer): assumed $35/visit for 11 visits (not counting initial visit since this cost would be the same for all therapies, oral or topical) and 3 bottles of Penlac® @ $37.17/bottle

# In the News



## Revised labeling for cerivastatin (Baycol®; Bayer)

In May 2001, Bayer distributed a “Dear Health Care Professional letter” describing labeling changes made to the cerivastatin (Baycol®) package insert. The letter emphasizes that the starting dose of Baycol is 0.4 mg once daily in the evening regardless of previous lipid therapy, with lipid determinations and possible dosage adjustments in four weeks. Only patients requiring further lipid adjustment should be titrated to 0.8mg. A 0.2-mg dose is recommended for patient with significant renal impairment (CrCl <60 mL/min). Bayer states that labeling changes were made following reports of myopathy and rhabdomyolysis that appeared to be associated with inappropriate use of cerivastatin, most commonly initial daily doses of 0.8 mg or concurrent gemfibrozil usage (contraindicated). Bayer's letter and changes in cerivastatin labeling are available on the FDA MedWatch site at: **www.fda.gov/medwatch/safety/2001/safety01.htm#Baycol.**

**Coming next issue: an updated look at statin therapy in DoD**

## Revised labeling for itraconazole (Sporanox®; Janssen) and terbinafine (Lamisil®; Novartis)

On 9 May 2001, the FDA issued a Public Health Advisory indicating that, because of the low but possible risk of cardiac toxicity, itraconazole (Sporanox®) should NOT be administered for the treatment of onychomycosis in patients with ventricular dysfunction such as CHF or a history of CHF. If signs or symptoms of CHF occur during treatment for onychomycosis, Sporanox® should be discontinued. If signs or symptoms of CHF occur during treatment for more serious systemic fungal infections, the use Sporanox® should be reassessed and other therapeutic options considered. The FDA believes that in 58 of 94 spontaneously reported cases of CHF in association with itraconazole use (Sep 1992 to Apr 2001), itraconazole contributed to or may have been the cause of CHF in 58 cases. [Itraconazole was being administered for the treatment of onychomycosis in 26 of the 58 cases.]

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# In the News

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Of the 58 cases, 28 were hospitalized, and death was reported in 13 cases. The causal relationship is unclear.

The public health advisory also reviews the association of both itraconazole and terbinafine (Lamisil®) with serious hepatic toxicity, including liver failure and death. Some cases involved patients who had neither pre-existing liver disease nor a serious underlying medical condition. As of April 2001, the FDA is aware of 16 cases of liver failure in association with oral terbinafine (including 11 deaths and two liver transplantations) and 24 cases of liver failure associated with itraconazole (including 11 deaths). Because of these risks, new labeling for these drugs recommends that **healthcare providers obtain nail specimens for laboratory testing prior to prescribing the medications for onychomycosis to confirm the diagnosis**.

Revisions to terbinafine labeling include strengthened precautions regarding liver disease. Labeling now states that:

> *"Lamisil is not recommended for patients with chronic or active liver disease. Before prescribing Lamisil Tablets, pre-existing liver disease should be assessed. Hepatotoxicity may occur in patients with and without pre-existing liver disease. Pretreatment serum transaminase (ALT and AST) tests are advised for all patients before taking Lamisil Tablets. Patients prescribed Lamisil (terbinafine HCl) Tablets should be warned to report immediately to their physician any symptoms of persistent nausea, anorexia, fatigue, vomiting, right upper abdominal pain, or jaundice, dark urine or pale stools (see WARNINGS). Patients with these symptoms should discontinue taking oral terbinafine, and the patient's liver function should be immediately evaluated."*

Revisions to itraconazole labeling also incorporate updated drug interaction information, including a contraindication for use of Sporanox with the Class III antiarrhythmic dofetilide (Tikosyn™), a precaution for use with erythromycin, and modifications of the calcium channel blocker drug interaction statement.

For more information, visit the FDA's Sporanox and Lamisil Public Health Advisory page: **www.fda.gov/cder/drug/advisory/sporanox-lamisil/default.htm**

## Does it say "Lamisil" or "Lamictal"?

Confusion of terbinafine with the similarly-named anticonvulsant lamotrigine (Lamictal) has resulted in drug dispensing errors. Terbinafine is available as a 250-mg tablet, while lamotrigine is available as 25-, 100-, 150-, and 200-mg tablets and 2-, 5-, and 25-mg chewable tablets. Terbinafine is dosed once daily, while lamotrigine may be dosed once or twice daily.

A summary of medication errors received by the USP Medication Errors Reporting (MER) Program that involve confusion between these two medications is available from the U.S. Pharmacopeia website (**www.usp.org**; look under Practitioner's Reporting News"). There were eleven reports as of Feb 01, seven of which resulted in the patient taking the wrong medication. An updated list of commonly confused drug names (U.S. Pharmacopeia Quality Review No. 76, March 2001), entitled "Use Caution—Avoid Confusion," is also available on the site. The link to the PDF version of the document is **www.usp.org/reporting/review/qr76.pdf**.

## Updated guidelines: Occupational exposure to hepatitis and HIV

The CDC has released new guidelines for the management of occupational exposures to HBV, HCV, and HIV, and recommendations for post-exposure prophylaxis. Consult the CDC website for further information: **http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf**

## Editor's Note

The PEC encourages MTFs to forward the e-newsletter directly to all providers or to incorporate pertinent articles into e-mail alerts, local newsletters, website postings, or other means of communication. The PEC Update is also formatted as a MS Word file and an Adobe Acrobat (pdf) file to facilitate printing and copying—just see the links at the top left hand corner of any page.

**Do you have an article you'd like to see published in the PEC Update?** Contact the editor at **shana.trice@amedd.army.mil,** or call: DSN 421-9551, Commercial (210) 295-9551

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